

American Arbitration Association
New York No-Fault Arbitration Tribunal

In the Matter of the Arbitration between:

Metro Healthcare Partners
(Applicant)

- and -

Kemper Independence Insurance Company
(Respondent)

AAA Case No. 17-23-1306-3872

Applicant's File No. 3002639

Insurer's Claim File No. 22123675259

NAIC No. 10914

ARBITRATION AWARD

I, Tracy Morgan, the undersigned arbitrator, designated by the American Arbitration Association pursuant to the Rules for New York State No-Fault Arbitration, adopted pursuant to regulations promulgated by the Superintendent of Insurance, having been duly sworn, and having heard the proofs and allegations of the parties make the following **AWARD**:

Injured Person(s) hereinafter referred to as: injured person-assignor

1. Hearing(s) held on 11/22/2023

Declared closed by the arbitrator on 12/11/2023

Scott Fisher, Esq. from Israel Purdy, LLP participated virtually for the Applicant

Christine Lee, Esq. from De Martini & Yi, LLP participated virtually for the Respondent

2. The amount claimed in the Arbitration Request, **\$749.03**, was NOT AMENDED at the oral hearing.

Stipulations WERE NOT made by the parties regarding the issues to be determined.

3. Summary of Issues in Dispute

The Applicant is the assignee of no-fault benefits from injured person-assignor (EK), a 49 year old female who reported she was involved in a motor vehicle accident as a driver on April 30, 2022. Following the accident, the injured person-assignor sought medical assistance and underwent chiropractic treatment on December 2, 2022 performed by Applicant. The injured person-assignor additionally underwent an office visit and injection on February 2, 2023 and physical therapy from December 14, 2022-March 2, 2023 performed by Applicant. Respondent denied Applicant's claims for December 2, 2021 and February 2, 2023 contending a lack of medical necessity based upon the Independent Medical Examinations performed by Glenn Berman, D.C. on July

20, 2022 and Vijay Sidhwani, D.O. on August 4, 2022. Respondent partially paid the remaining claims and denied the balance contending that Applicant billed in excess of the maximum amount allowed under the fee schedule.

The issues presented on this arbitration are whether the services in dispute were medically necessary and whether Respondent properly reimbursed Applicant in accordance with the fee schedule?

4. Findings, Conclusions, and Basis Therefor

This hearing was conducted using documents contained in ADR Center. Any documents contained in the folder are hereby incorporated into this hearing. I have reviewed the relevant exhibits contained in the electronic file maintained by the American Arbitration Association and have considered all of the stipulations and arguments presented by both parties at the hearing of this matter. No witnesses appeared or testified.

The parties were afforded time after the hearing to address Respondent's contention that the amount of \$114.59 was reimbursed to Applicant for date of service December 22, 2022. Respondent uploaded a cashed check and Applicant did not submit any contentions to counter Respondent's proof.

I find that Applicant established its prima facie entitlement to no-fault benefits as proofs of claim were mailed to and received by the insurer and payment of No-Fault benefits is overdue *See Insurance Law § 5106 [a]; 11 NYCRR 65.15 [g]; Viviane Etienne Medical Care, P.C. v Country-Wide Ins. Co.*, 25 NY3d 498 (2015).

December 2, 2021

For date of service December 2, 2021, Applicant billed for chiropractic treatment rendered pursuant to CPT Code 98941 in the amount of \$57.30. Respondent timely denied the claim contending a lack of medical necessity based upon the Independent Medical Examinations performed by Glenn Berman, D.C. on July 20, 2022. Respondent additionally contended that the maximum amount of reimbursement has been made for this date of service.

Where a health care provider establishes its prima facie entitlement to no-fault benefits, the burden shifts to the insurer to prove that the medical services were not medically necessary *Nir v Allstate Ins. Co.*, 7 Misc3d 544 (2005); *Amaze Medical*

Supply Inc. v Eagle Insurance Co., 2 Misc3d 128(A), 2003 NY Slip Op 51701(U)(App Term 2d, 11th & 13th Dists). Respondent bears the burden of production in support of its lack of medical necessity defense, which if established, shifts the burden of persuasion to applicant *See generally, Bronx Expert Radiology, P.C. v Travelers Ins. Co.*, 2006 NY Slip Op 52116 (App Term 1st Dept, 2006).

In determining whether an insurer met its burden of proof in establishing its lack of medical necessity defense, the courts have found that an insurer must submit a report with a detailed basis and medical rationale for the denial of benefits in order to prevail *See Vladimir Zlatnick, M.D., P.C. v. Travelers Ins. Indemnity Co.*, 12 Misc3d 128A (App Term 1 Dept, 2006). *See also Nir v. Allstate*, 7 Misc.3d 544 (2005) "At a minimum, (Respondent) must establish a factual basis and medical rationale for the lack of medical necessity of (Applicant's) services". Once Respondent submits an IME report or peer review that has a sufficient factual basis and medical rationale, then the courts have routinely found that Respondent has established its prima facie defense that the disputed medical service is medically unnecessary *A Khodadadi Radiology, P.C. v NY Cent. Mut. Fire Ins. Co.*, 16 Misc3d 131(A), 2007 NY Slip Op 51342(U) (App Term 2d & 11th Dists, 2007). *See also, Dayan v Allstate Ins. Co.*, 49 Misc3d 151(A), 2015 NY Slip Op 51751(U) (App Term 2d, 11th & 13th Dists, 2015).

As of the date of this hearing, there was no IME report by Glenn Berman, D.C. submitted on this Record. Respondent's denial specifically denied the claim based upon the findings and conclusions contained within the IME report of Dr. Berman. Respondent's evidence, including the medical records submitted, is insufficient to establish a lack of medical necessity for the services in dispute. I find that Respondent has failed to set forth a cogent medical rationale in support of its defense of lack of medical necessity.

However, the Record includes Respondent's Explanation of Review indicating that payment was remitted to Applicant for physical therapy services provided to the same injured person-assignor on the same date in the total amount of \$114.59 pursuant to CPT Codes 97110, 97014 and 97124.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defense *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc3d 172 (Civ. Ct. Kings Co., 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained *See Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc3d 145A (App Term, 1st Dep't, per curiam, 2006).

In accordance with New York Workers' Compensation Medical Fee Schedule, Ground Rule 11; Chiropractic Fee Schedule that became effective on October 1, 2020,

the maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs for all providers combined.

I find that Respondent demonstrated that it already paid Applicant for physical therapy services in the amount of 12 units minus 1 cent. The correct calculation of 12 units is \$114.60. As Respondent proved they paid \$114.59, Applicant is owed .01 for its claim for date of service December 2, 2021.

December 14, 2021-January 31, 2023 & February 7, 2023-March 2, 2023

For dates of service December 14, 2021-January 31, 2023 & February 7, 2023-March 2, 2023, Applicant billed the amount of \$114.60 per day for physical therapy services rendered under CPT Codes 97124, 97014 and 2 units of 97110. Respondent reimbursed Applicant in the amount of \$114.59 for December 14, 2022. As to date of service December 22, 2022, Respondent uploaded a copy of a cashed check in the amount of \$114.59. For the remaining dates of service, Respondent reimbursed Applicant in the amount of \$104.25 per day. Respondent's explanation for denying the balances of the claims is that the daily RVU maximum of 12 units had been exhausted.

Respondent has the burden of coming forward with competent evidentiary proof to support its fee schedule defense *See Robert Physical Therapy PC v. State Farm Mutual Auto Ins. Co.*, 13 Misc3d 172 (Civ. Ct. Kings Co., 2006). If Respondent fails to demonstrate by competent evidentiary proof that a plaintiff's claims were in excess of the appropriate fee schedules, defendant's defense of noncompliance with the appropriate fee schedules cannot be sustained *See Continental Medical PC v. Travelers Indemnity Co.*, 11 Misc3d 145A (App Term, 1st Dep't, per curiam, 2006).

The New York State Workers' Compensation Physical & Occupational Therapy Fee Schedule that became effective on October 1, 2020, applies to this claim. In accordance with Ground Rule 3 Multiple Physical Medicine Procedures and Modalities, the maximum reimbursement limitations per patient per day per accident or illness for modalities is 12.0 RVUs for all providers combined.

Applicant's bill indicates that the services were rendered by owner Juna Rago, PT in Brooklyn, New York under zip code 11229 which is classified as Region IV. The proper conversion factor listed for physical medicine in the physical and occupational therapy fee schedule is 9.55.

There is no proof of other payments made for these dates of service. Applicant properly billed 12 units which calculates to \$114.60. The balance of Applicant's claim for these dates of service is awarded.

February 2, 2023

For date of service February 2, 2023, Applicant billed for an office visit and injections. Respondent timely denied Applicant's claim contending a lack of medical necessity based upon the Independent Medical Examination performed by Vijay Sidhwani, D.O. on August 4, 2022.

Respondent relies upon the IME report of Dr. Sidhwani to support its denial of claim. The injured person-assignor presented to Dr. Sidhwani for an IME with current complaints of pain in the neck, low back, left shoulder and left arm. Dr. Sidhwani found that motor strength was 5/5, reflexes were 2+ and sensation was intact throughout. There was no tenderness in the cervical, thoracic or lumbar regions of her spine. Ranges of motion were within normal limits. Orthopedic testing including cervical compression, Spurling's, straight leg raises and Patrick's tests was negative. Bilateral shoulder assessment yielded restricted ranges of motion for the right and left shoulder but there was no tenderness and drop arm test, Apprehension, Neer's and Hawkin's tests were negative. Dr. Sidhwani's impression was of sprains/strains of the affected areas resolved. He commented that range of motion is subjective and that the injured person-assignor reached an endpoint to treatment.

I find that Dr. Sidhwani's report is insufficient to establish a lack of medical necessity due to the positive findings for the right and left shoulder. Dr. Sidhwani concluded that the positive findings were subjective and unsupported and that the injured person-assignor reached an endpoint in treatment. Such opinion does not factually establish a diagnosis that the conditions have resolved *Cuevas v. Compote Cab Corp.*, 61 AD3d 812, 878 NYS2d 124 (2d Dept. 2009); *Torres v. Garcia*, 59 AD3d 705, 874 NYS2d 527 (2d Dept. 2009). An IME report must set forth a factual basis and medical rationale for the conclusion that services are not medically necessary *See Ying Eastern Acupuncture, P.C. v Global Insurance*, 20 Misc3d 144(A), 2008 NY Slip Op 51863(U) (App Term 2d & 11th Dists, Sept. 3, 2008). Dr. Sidhwani's conclusions are lacking and insufficient to carry Respondent's burden of proof on the issue of medical necessity.

Notwithstanding, the Record contains contemporaneous physical therapy reports of August 3, 2022, August 22, 2022 and August 29, 2022 documenting continued complaints of cervical and lumbar pain as well as left shoulder pain, left wrist pain, left knee pain and left ankle pain. Cervical and thoracic tenderness was noted as well as cervical trigger points. Ranges of cervical and lumbar motion were restricted and straight leg raises were positive. Trigger points were detected in the cervical region and there was tenderness and spasm in the lumbar region. Left shoulder tenderness was

noted and left shoulder ranges of motion were decreased. Limited ranges of motion were also noted for the left hip, knee and ankle. The left wrist had tenderness over the TFCC. A continued course of physical therapy was recommended.

The physical therapy reports sufficiently rebut Dr. Sidhwani's findings and conclusions and I am persuaded by the records contemporaneous with Dr. Sidhwani's IME that further therapy was warranted. It is additionally determined that Applicant has sufficiently demonstrated the medical necessity of the within services and rebutted the conclusions of Respondent's expert. Accordingly, Applicant's claim for February 2, 2023 is also awarded. Any further issues raised in the hearing record are held to be moot and/or waived insofar as not raised at the time of the hearing.

5. Optional imposition of administrative costs on Applicant.
Applicable for arbitration requests filed on and after March 1, 2002.

I do NOT impose the administrative costs of arbitration to the applicant, in the amount established for the current calendar year by the Designated Organization.

6. **I find as follows with regard to the policy issues before me:**
- ☐ The policy was not in force on the date of the accident
 - ☐ The applicant was excluded under policy conditions or exclusions
 - ☐ The applicant violated policy conditions, resulting in exclusion from coverage
 - ☐ The applicant was not an "eligible injured person"
 - ☐ The conditions for MVAIC eligibility were not met
 - ☐ The injured person was not a "qualified person" (under the MVAIC)
 - ☐ The applicant's injuries didn't arise out of the "use or operation" of a motor vehicle
 - ☐ The respondent is not subject to the jurisdiction of the New York No-Fault arbitration forum

Accordingly, the applicant is AWARDED the following:

A.

Medical		From/To	Claim Amount	Status
	Metro Healthcare Partners	12/02/22 - 12/02/22	\$57.30	Awarded: \$0.01
	Metro Healthcare Partners	12/14/22 - 12/14/22	\$11.65	Awarded: \$0.01

	Metro Healthcare Partners	12/22/22 - 12/22/22	\$126.24	Awarded: \$0.01
	Metro Healthcare Partners	01/03/23 - 01/03/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	01/04/23 - 01/04/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	01/19/23 - 01/19/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	01/24/23 - 01/24/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	01/31/23 - 01/31/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	02/09/23 - 02/09/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	02/07/23 - 02/07/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	02/02/23 - 02/02/23	\$439.99	Awarded: \$439.99
	Metro Healthcare Partners	02/14/23 - 02/14/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	02/21/23 - 02/21/23	\$10.35	Awarded: \$10.35
	Metro Healthcare Partners	02/28/23 - 02/28/23	\$10.35	Awarded: \$10.35

	Metro Healthcare Partners	03/02/23 - 03/02/23	\$10.35	Awarded: \$10.35
Total			\$749.03	Awarded: \$553.87

- B. The insurer shall also compute and pay the applicant interest set forth below. 07/05/2023 is the date that interest shall accrue from. This is a relevant date only to the extent set forth below.

Applicant is awarded interest pursuant to the no-fault regulations. See generally, 11 NYCRR §65-3.9. Interest shall be calculated "at a rate of two percent per month, calculated on a pro rata basis using a 30 day month." 11 NYCRR §65-3.9(a). A claim becomes overdue when it is not paid within 30 days after a proper demand is made for its payment. However, the regulations toll the accrual of interest when an applicant "does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations." See, 11 NYCRR 65-3.9(c). The Superintendent and the New York Court of Appeals has interpreted this provision to apply regardless of whether the particular denial at issue was timely LMK Psychological Servs., P.C. v. State Farm Mut. Auto. Ins. Co., 12 NY3d 217 (2009).

C. Attorney's Fees

The insurer shall also pay the applicant for attorney's fees as set forth below

As this matter was filed on or after February 4, 2015, this case is subject to the provisions promulgated by the Department of Financial Services in the Sixth Amendment to 11 NYCRR 65-4 (Insurance Regulation 68-D). Accordingly, the insurer shall pay the applicant an attorney's fee, in accordance with newly promulgated 11 NYCRR 65-4.6(d) For claims that fall under the Sixth Amendment to the regulation, the following shall apply: "If the claim is resolved by the designated organization at any time prior to transmittal to an arbitrator and it was initially denied by the insurer or overdue, the payment of the applicant's attorney's fee by the insurer shall be limited to 20 percent of the total amount of first-party benefits and any additional first-party benefits, plus interest thereon, for each applicant with whom the respective parties have agreed and resolved dispute, subject to a maximum fee of \$1,360.00."

- D. The respondent shall also pay the applicant forty dollars (\$40) to reimburse the applicant for the fee paid to the Designated Organization, unless the fee was previously returned pursuant to an earlier award.

This award is in full settlement of all no-fault benefit claims submitted to this arbitrator.

State of NY

SS :

County of Nassau

I, Tracy Morgan, do hereby affirm upon my oath as arbitrator that I am the individual described in and who executed this instrument, which is my award.

12/12/2023

(Dated)

Tracy Morgan

IMPORTANT NOTICE

This award is payable within 30 calendar days of the date of transmittal of award to parties.

This award is final and binding unless modified or vacated by a master arbitrator. Insurance Department Regulation No. 68 (11 NYCRR 65-4.10) contains time limits and grounds upon which this award may be appealed to a master arbitrator. An appeal to a master arbitrator must be made within 21 days after the mailing of this award. All insurers have copies of the regulation. Applicants may obtain a copy from the Insurance Department.

ELECTRONIC SIGNATURE

Document Name: Final Award Form
Unique Modria Document ID:
29b727668d3b4cfd2270894e1e172a2d

Electronically Signed

Your name: Tracy Morgan
Signed on: 12/12/2023